Lincoln-Way Area Special Education
Joint Agreement District 843

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AUTHORIZATION TO ADMINISTER REQUIRED TREATMENT DURING SCHOOL HOURS

Student's Name ______________________ Birth Date ______________________

Address ______________________ Phone Number ______________________

School/Teacher ______________________ Grade ______________________

Emergency Contact Name and Phone Number ______________________

I. TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

The aboved named student is under my medical care and is required to have the following treatment administered during school hours:

Diagnosis: ______________________

Treatment Order: ______________________

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Frequency of Treatment: ______________________

Duration of Treatment: ______________________

Equipment Needed: ______________________

Side Effects: ______________________

____

To what degree can the student participate in treatment?

Independent: ☐ Needs Assistance: ☐ Unable to Assist: ☐

I may be reached at the following phone munber in the event of an emergency.

______________________ ______________________
Phone Number of Physician Signature of Physician Date

______________________ ______________________
Address of Physician Print Name of Physician

II. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN:

I, ____, parent or guardian of ______________________________, authorize my child to receive the treatment listed on page 1 as directed by my child's physician. I understand that I am primarily responsible for providing such treatment to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Lincoln-Way Area Special Education Joint Agreement District 843, and its employees and agents, on my behalf and in my stead, to provide my child the treatment listed on page 1 in the manner described by my child's physician. I acknowledge that it may be necessary for such treatment to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the treatment is discontinued and will obtain a written order from the physician if the treatment is changed. I understand that I am responsible for providing all the necessary supplies to conduct the treatment and will ensure such are provided.

I further acknowledge and agree that, when the treatment is so administered, I waive any claims I might have against Lincoln-Way Area Special Education Joint Agreement District 843, and its employees and agents, arising out of the administration of said treatment. In addition, I agree to indemnify and hold harmless Lincoln-Way Area Special Education Joint Agreement District 843, and its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said treatment, except a claim based on willful or wanton conduct.

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Parent/Guardian Signature Date